SUMMARY OF MATERIAL MODIFICATIONS
TO THE
CHIPPEWA FALLS AREA UNIFIED SCHOOL DISTRICT
EMPLOYEE BENEFIT PLAN

This Summary of Material Modifications ("SMM") amends certain provisions of your Summary Plan Description ("SPD") for the Chippewa Falls Area Unified School District Employee Benefit Plan (the "Plan"). Please review this SMM carefully to familiarize yourself with the changes and please attach this SMM to the front of your SPD.

The following changes to the plan have been approved and are effective January 1, 2016:

1. **Plan Notices** – removed Grandfathered Notice and replaced with the following:

   Non-Grandfathered Health Plan Notice:
   This Chippewa Falls Area Unified School District Employee Benefit Plan believes that this Plan is a "non-grandfathered health plan" under the Affordable Care Act (ACA).

2. **Schedule of Benefits – Standard Plan** – amended deductible and max out-of-pocket amounts.

BENEFIT DESCRIPTION	**PREFERRED PROVIDER**	**NON-PREFERRED PROVIDER** (Subject to Usual and Customary and Reasonable Charges)
CALENDAR YEAR DEDUCTIBLE		
Individual	$500	
Family (Embedded)	$1,000	
MAXIMUM OUT-OF-POCKET AMOUNT PER CALENDAR YEAR		
Individual	$1,500	
Family (Embedded)	$3,000	

3. **Schedule of Benefits – Standard Plan** – amended to apply copays to max out-of-pocket expense.

The following charges are excluded from the major medical deductible requirement or maximum out-of-pocket expense and are never paid at 100%:

- Ineligible Charges
- Charges in excess of the Plan maximums/limitations
- Charges over the Usual and Customary and Reasonable Fee

Note:

1. **Maximum out-of-pocket includes the major medical deductible;**
2. **Deductible and/or maximum out-of-pocket amounts are combined for Preferred Provider and non-Preferred Provider expenses;**
3. **Copays apply towards the maximum out-of-pocket expense.**

4. **Schedule of Benefits – Standard Plan –** amended to cover non-PPO at PPO level per ACA regulations.

Ambulance Services Includes air transportation to the nearest, most appropriate medical facility.	90% after Deductible	90% after PPO Deductible, Usual and Customary and Reasonable apply

5. **Schedule of Benefits – Standard Plan –** amended to cover at 100% per ACA regulations.

Contraceptives	100% Deductible waived	80% after Deductible

6. **Schedule of Benefits – Standard Plan –** amended for clarification.

Emergency Room Services Includes facility charge, Physician fee and miscellaneous Hospital expenses.	$50 Copay, then 90% after Deductible	$50 Copay, then 90% after PPO Deductible, Usual and Customary and Reasonable apply

7. **Schedule of Benefits – Standard Plan –** added ACA-required language.

Maternity Services Maternity charges not included under the Preventive Services benefit.	90% after Deductible	80% after Deductible

8. **Schedule of Benefits – Standard Plan –** added ACA-required language.

Prescription Drugs Retail (90-day supply) Mail Order (90-day supply) Specialty Drugs (30-day supply)	 90% after Deductible 90% after Deductible 90% after Deductible	 80% after Deductible Not Covered Not Covered
Healthcare Reform (ACA) – Preventive drugs are covered at 100%, not subject to deductible or coinsurance (Generic and single source Brand only).		

9. **Schedule of Benefits – Standard Plan –** amended for preventive services changes.

Preventive Care Services Colonoscopy/Sigmoidoscopy	100% Deductible waived	80% after Deductible
Preventive Care Services Immunizations – age 6 and under Immunizations – over age 6	 100% Deductible waived 100% Deductible waived	 100% Deductible waived 80% after Deductible
Preventive Care Services Mammogram	100% Deductible waived	80% after Deductible

Preventive Care Services Office visit, gynecological exam, routine physical examination	100% Deductible waived	80% after Deductible
Preventive Care Services All other services related to the preventive care exam Including but not limited to pap smear, prostate screening, x-rays, lab tests, routine hearing exams for dependent children under age 18, and other routine procedures (i.e., bone density tests, lead screening under age 6, etc.). *To comply with statutes and regulations, the preventative services are outlined in the Covered Expenses section in their entirety.*	100% Deductible waived	80% after Deductible
Screenings and other services are generally covered as preventive care for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service. Participants who have current symptoms or have been diagnosed with a medical condition are not considered to require preventive care for that condition, except as specifically provided under the Plan.		
Preventive Care Services Breast Pump	100% Deductible waived	80% after Deductible
Maximum benefit	One pump in conjunction with each birth	
Breast pumps purchased from a retail store must be paid for up front and the receipt submitted to the Claims Administrator for reimbursement. Reimbursement will be based on the Preferred Provider level of benefits and Usual and Customary and Reasonable does not apply.		

10. **Schedule of Benefits – HDHP –** amended deductible and max out-of-pocket amounts.

BENEFIT DESCRIPTION	**PREFERRED PROVIDER**	**NON-PREFERRED PROVIDER** (Subject to Usual and Customary and Reasonable Charges)
CALENDAR YEAR DEDUCTIBLE Individual Family (Non-Embedded)	$1,500 $3,000	
MAXIMUM OUT-OF-POCKET AMOUNT PER CALENDAR YEAR Individual Family (Non-Embedded)	$1,500 $3,000	$2,000 $4,000

11. **Schedule of Benefits – HDHP –** amended PPO coinsurance percentage.

After the deductible has been satisfied, allowable charges will be paid at 100 percent or 80 percent until the maximum out-of-pocket expense amount is met. Allowable charges from Preferred Providers will be paid at 100 percent. Allowable charges from all other qualified providers will be paid at 80 percent. Once the maximum out-of-pocket expense amount is met, the Plan will then pay 100 percent of all allowable charges.

12. **Schedule of Benefits – HDHP –** amended to apply copays to max out-of-pocket expense.

The following charges are excluded from the major medical deductible requirement or maximum out-of-pocket expense and are never paid at 100%: • Ineligible Charges • Charges in excess of the Plan maximums/limitations • Charges over the Usual and Customary and Reasonable Fee
Note: **1. Maximum out-of-pocket includes the major medical deductible;** **2. Deductible and/or maximum out-of-pocket amounts are combined for Preferred Provider and non-Preferred Provider expenses;** **3. Copays apply towards the maximum out-of-pocket expense.**

13. **Schedule of Benefits – HDHP –** amended coinsurance amounts, amended emergency language for clarification, added ACA-required language, and amended for preventive services changes.

BENEFIT DESCRIPTION	**PREFERRED PROVIDER**	**NON-PREFERRED PROVIDER** (Subject to Usual and Customary and Reasonable Charges)
Allergy Tests and Injections	100% after Deductible	80% after Deductible
Ambulance Services Includes air transportation to the nearest, most appropriate medical facility.	100% after Deductible	100% after PPO Deductible, Usual and Customary and Reasonable apply
Ambulatory/Outpatient Surgery Care	100% after Deductible	80% after Deductible
Anesthesia Inpatient/Outpatient	100% after Deductible	80% after Deductible
Autism Spectrum Disorder Treatment Calendar Year benefit is limited to the annual Intensive level and Non-Intensive level specified by state law statute 632.895. These amounts change each year based on the Consumer Price Index.	100% after Deductible	80% after Deductible

Birthing Center Care	100% after Deductible	80% after Deductible
Consultant (In-Hospital)	100% after Deductible	80% after Deductible
Chiropractic/Spinal Manipulation Includes office visit, x-rays, manipulations and supportive care.	100% after Deductible	80% after Deductible
Calendar Year maximum benefit	18 visits	
Contraceptives	100% Deductible waived	80% after Deductible
Dental Services Accidental Injury/Oral Surgical Procedures	100% after Deductible	80% after Deductible
Durable Medical Equipment	100% after Deductible	80% after Deductible
Emergency Room Services Includes facility charge, Physician fee and miscellaneous Hospital expenses.	100% after Deductible, $50 Copay applies after Deductible is satisfied	100% after PPO Deductible, Usual and Customary and Reasonable apply, $50 Copay applies after Deductible is satisfied
Hearing Aids Children under 18 years of age – Limited to one aid per ear every 36 months. Also includes cochlear implants.	100% after Deductible	Not Covered
Hemodialysis	100% after Deductible	80% after Deductible
Home Health Care Services	100% after Deductible	80% after Deductible
Calendar Year maximum benefit	40 visits	
Hospice	100% after Deductible	80% after Deductible
Hospital Preadmission Testing	100% after Deductible	80% after Deductible
Hospital Physician Visits	100% after Deductible	80% after Deductible
Hospital Services	100% after Deductible	80% after Deductible
Maternity Services Maternity charges not included under the Preventive Services benefit.	100% after Deductible	80% after Deductible
Mental/Nervous Disorders and/or Substance Abuse Inpatient/Outpatient Treatment	100% after Deductible	80% after Deductible
Physician/Clinic Office Visit Includes office visit charge only.	100% after Deductible	80% after Deductible
Physician Fees for Surgical and Medical Services	100% after Deductible	80% after Deductible

Prescription Drugs Retail (90-day supply) Mail Order (90-day supply) Specialty Drugs (30-day supply)	 100% after Deductible 100% after Deductible 100% after Deductible	 80% after Deductible Not Covered Not Covered
Healthcare Reform (ACA) – Preventive drugs are covered at 100%, not subject to deductible or coinsurance (Generic and single source Brand only).		
If you are without your ID card or use a non-participating pharmacy, you must pay for the prescription and submit a claim to the Prescription Drug Card service. A completed claim form and the paid receipt must be submitted as proof of claim. If the prescription drug is covered under the plan, reimbursement will be based on 100% of submitted charges less the applicable deductible/coinsurance.		
Preventive Care Services Colonoscopy/Sigmoidoscopy	100% Deductible waived	80% after Deductible
Preventive Care Services Immunizations – age 6 and under Immunizations – over age 6	 100% Deductible waived 100% Deductible waived	 100% Deductible waived 80% after Deductible
Preventive Care Services Mammogram	100% Deductible waived	80% after Deductible
Preventive Care Services Office visit, gynecological exam, routine physical examination	100% Deductible waived	80% after Deductible
Preventive Care Services All other services related to the preventive care exam Including but not limited to pap smear, prostate screening, x-rays, lab tests, routine hearing exams for dependent children under age 18, and other routine procedures (i.e., bone density tests, lead screening under age 6, etc.) *To comply with statutes and regulations, the preventative services are outlined in the Covered Expenses section in their entirety.*	100% Deductible waived	80% after Deductible
Screenings and other services are generally covered as preventive care for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service. Participants who have current symptoms or have been diagnosed with a medical condition are not considered to require preventive care for that condition, except as specifically provided under the Plan.		
Preventive Care Services Breast Pump	100% Deductible waived	80% after Deductible
Maximum benefit	One pump in conjunction with each birth	
Breast pumps purchased from a retail store must be paid for up front and the receipt submitted to the Claims Administrator for reimbursement. Reimbursement will be based on the Preferred Provider level of benefits and Usual and Customary and Reasonable does not apply.		

Skilled Nursing Facility Per confinement maximum benefit	100% after Deductible 120 days	80% after Deductible
Surgery Inpatient/Outpatient	100% after Deductible	80% after Deductible
Temporomandibular Joint Disorder Services	100% after Deductible	80% after Deductible
Therapy Services	100% after Deductible	80% after Deductible
Transplants	100% after Deductible	80% after Deductible
Urgent Care Includes facility charge, Physician charge and other urgent care expenses.	100% after Deductible	80% after Deductible
Virtual Care	100% after Deductible	Not Covered
X-ray, Laboratory and Pathology Services	100% after Deductible	80% after Deductible
All Other Covered Expenses	100% after Deductible	80% after Deductible

14. **Comprehensive Medical Coverages –** <u>added</u> for clarification.

Right to Consider Substitution for Covered Charges

The Claims Administrator shall have the right to consider alternate charges Incurred for treatment, services or supplies not specifically listed as covered charges for payment of benefits under this Plan. The charges will be considered at the Plan Administrator's sole option and:

A. must have the knowledge and consent of the covered individual Participant; and
B. must be prescribed and approved by the Physician and be generally accepted and approved by the medical profession; and
C. must offer a medical therapeutic value equal to the treatment or service that would otherwise be performed or given; and
D. must be Medically Necessary.

The Plan Administrator may cease to pay benefits for these substitute treatments, services or supplies at any time with written notification to the covered participant.

15. (Item I) **Covered Expenses –** <u>amended</u> for clarification.

I. Charges for the following providers:
   4. Physical, Occupational and respiratory therapy performed by a Physician or licensed Physical, Occupational or respiratory therapist. The therapist must be providing the therapy under the direction of a Physician. Charges for pool therapy, aquatic therapy and hydrotherapy is also recognized as Physical Therapy when performed by a Physical Therapist or other recognized licensed provider for Physical Therapy modalities, administered in a pool; which requires direct one-on-one patient contact. The therapist must be providing the therapy under the direction of a Physician for a condition that is Medically Necessary, Reasonable and appropriate for Physical Therapy treatment. Therapy will end when:

a. treatment goals have been reached; or
b. no substantive change is seen by the patient's condition after a reasonable period; or
c. maximum medical improvement has been reached.

16. (Item N) **Covered Expenses –** amended to reflect coverage based on non-grandfather status.

N. Prescription Drugs and Medicines – The Plan shall automatically be updated to reflect new recommendations to the prescription drug preventive benefits schedule as established by the Affordable Care Act (ACA) as amended. For the most current listing of evidence based A and B rated preventive services, please visit the U.S. Preventive Task Force (USPSTF) website at http://www.uspreventiveservicestaskforce.org. For a paper copy, please contact the Plan Administrator.

Drugs Covered

1. legend drugs. Exceptions: See Exclusion list below;
2. amphetamines;
3. anabolic steroids;
4. anorectics (any drug used for the purpose of weight loss);
5. antivirals, specifically indicated for the treatment of HIV/AIDS;
6. blood components and products including blood component injectables;
7. blood glucose monitors; ABBOTT products only;
8. *contraceptives, oral or other, whether medication or device. Over the counter (OTC) requires a prescription;
9. compounded medication of which at least one ingredient is a legend drug;
10. erectile dysfunction drugs, all dosage forms (Viagra is limited to 10 pills per 30 days);
11. *folic acid supplements. Over the counter (OTC) requires a prescription;
12. growth hormones;
13. *immunizations;
14. insulin;
15. disposable insulin needles/syringes;
16. insulin injection devices, disposable blood/urine glucose/acetone testing agents (e.g., Chemstrips, Acetest tablets, Clinitest tablets, Diastix Strips and Test-Tape);
17. lancets;
18. OTC Prilosec, OTC Claritin and OTC Zyrtec, including equivalent agents, covered only with a prescription;
19. prenatal vitamins requiring a prescription;
20. Ranitidine, Famotidine and Cimetidine;
21. *smoking deterrent medications. Over the counter (OTC) requires a prescription;
22. *aspirin to prevent cardiovascular disease. Over the counter (OTC) requires a prescription;
23. *aspirin to prevent preeclampsia. Over the counter (OTC) requires a prescription;
24. *bowel preps for use in colorectal cancer screening. Over the counter (OTC) requires a prescription;
25. *breast cancer chemoprevention medications;
26. *iron supplements. Over the counter (OTC) requires a prescription;
27. *oral fluoride supplements. Over the counter (OTC) requires a prescription;
28. *vitamin D supplements. Over the counter (OTC) requires a prescription;
29. Tretinoin Topical (e.g., Retin-A);
30. any other drug which under the applicable state law may only be dispensed upon the written prescription of a Physician or other lawful prescriber.

* Type and dosage of medications, as well as age and gender criteria, are determined based on Affordable Care Act (ACA) requirements and recommendations by the U.S. Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP) and Health Resources and Services Administration (HRSA). Contact your Pharmacy Benefit Manager for the most current listing of covered medications.

Exclusions

5. fluoride (topical fluoride dental products), other than those listed above;
10. smoking deterrent medications containing nicotine or any other smoking cessation aids, other than those listed above;

17. (Item N) **Covered Expenses –** added for clarification.

Specialty Medications

Your pharmacy benefit program may include coverage for certain products that are referred to as Specialty Medications. Medications covered under this provision include, but are not limited to, immunosuppressants, antiretrovirals, cancer therapies, recombinant biological pharmaceuticals, interferons, growth hormones, drugs to treat other rare disorders and most injectable medications (except those specifically covered under the Prescription Drug Expense Benefit provision of this Plan).

If you are unsure if your medication is considered a specialty drug, please call the NPS helpdesk at (800) 546-5677 for further clarification concerning your medication.

Most Specialty Medications are injectables; however, some may be oral or transdermal. Specialty Medications may be medications that you administer to yourself or have a healthcare provider administer to you. When a Physician administers a covered Specialty Medication, you may be responsible to procure the product and take to your appointment with you. If Specialty Medications are covered under your pharmacy benefit and you choose to have the medication administered at your Physician's office, you may be billed for an office visit in addition to your prescription.

18. (Item CC) **Covered Expenses –** amended per ACA requirement.

CC. Contraceptives, whether medication or device, requiring a prescription, regardless of purpose. Prescription contraceptives that a Covered Participant self-administers will be processed under the prescription drug section of this Plan (oral tablets, patches, and self-insertable vaginal devices containing contraceptive hormones). Prescription contraceptives that require a Physician to fit and/or administer a hormone shot or insert/remove a device) will be processed under the medical benefits of this Plan. Benefits are payable at 100% not subject to deductible or coinsurance when performed by a Preferred Provider.

19. (Item LL) **Covered Expenses –** added for clarification.

LL. Charges for acupuncture or acupressure when administered by an MD or DO.

20. (Item MM) **Covered Expenses –** added for current U.S. Task Force Preventive Services.

MM. **Preventive Care services are outlined below in their entirety to comply with statutes and regulations.** The Plan shall automatically be updated to reflect new recommendations to the preventive benefits schedule as established by the Affordable Care Act (ACA) as amended. For the most current listing of evidence-based A and B rated preventive services, please visit the U.S. Preventive Task Force (USPSTF) website at http://www.uspreventiveservicestaskforce.org. For a paper copy, please contact the Plan Administrator. Covered Expenses will be payable, as shown in the Schedule of Benefits, for the following services. Checkups or routine examinations include the office visit and related charges for:

Preventive Services for Adults

- Abdominal Aortic Aneurysm one time screening for men ages 65 to 75 who have ever smoked
- Alcohol misuse screening and counseling
- Aspirin use to prevent cardiovascular disease for men ages 45 to 79 and women ages 55 to 79
- Blood pressure screening
- Bowel preps for use in colorectal cancer screening for adults age 50 through 75
- Cholesterol screening for men ages 20 to 35 years for lipid disorders if they are at increased risk for coronary heart disease, for men age 35 years and older for lipid disorders and for women ages 20 and older for lipid disorders if they are at increased risk for coronary heart disease
- Colorectal Cancer screening for adults beginning at age 50 years and continuing until age 75 years. Screening includes fecal occult blood testing, sigmoidoscopy, colonoscopy, computed tomographic colonography (virtual colonoscopy). This includes all related surgical and pathology services furnished in the same clinical encounter of the colorectal cancer screening should the screening (diagnostic) procedure be converted to a therapeutic procedure.
- Depression screening
- Type 2 Diabetes screening for adults ages 40 to 70 years who are overweight or obese
- Diet and physical activity counseling for adults at higher risk for chronic disease. This may include diabetes, impaired glucose tolerance (IGT), hyperlipidemia/high cholesterol, hypertension, obesity or Morbid Obesity
- Hepatitis B screening for adults at high risk for infection
- Hepatitis C virus infection screening for adults at high risk for infection and one-time screening for adults born between 1945 and 1965
- HIV screening for adults ages 18 to 65 years and for older adults who are at increased risk
- Immunization vaccines for adults – doses, recommended ages and recommended populations vary:
  - Hepatitis A
  - Hepatitis B
  - Herpes Zoster (shingles)
  - Human Papillomavirus (HPV)
  - Influenza (flu)
  - Measles, Mumps, Rubella
  - Meningococcal (e.g., meningitis)
  - Pneumococcal (e.g., pneumonia)
  - Tetanus, Diphtheria, Pertussis (whooping cough)
  - Varicella (chicken pox)

- Lung cancer annual screening with low-dose computed tomography in adults ages 55 to 80 years who have a 30-pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.
- Obesity screening for all adults followed by intensive, multicomponent behavioral interventions for adults with a body mass index of 30 kg/m^2 or higher
- Prevention of falls – Physical Therapy for community dwelling adults age 65 and older who are at risk for falls
- Prostate-Specific Antigen (PSA) Test
- Sexually transmitted infections – Intensive behavioral counseling for adults who are at increased risk for sexually transmitted infections.
- Skin cancer behavioral counseling for adults ages 18 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk
- Syphilis screening for adults at increased risk
- Tobacco use screening and behavioral interventions and FDA-approved pharmacotherapy for cessation for all adult tobacco users
- Vitamin D supplements for adults 65 years and older OTC Only

Preventive Services for Women, including Pregnant Women

- Anemia screening on a routine basis for pregnant women
- Bacteriuria urinary tract or other infection screening for pregnant women at 12 to 16 weeks' gestation or at the first prenatal visit, if later
- BRCA counseling about genetic testing for women at higher risk. This includes referral for genetic counseling and genetic testing, if appropriate.
- Breast Cancer Chemoprevention counseling and medications for women at higher risk
- Breast Cancer Mammography screenings. Frequency Limitation: 1 exam per calendar year. Those Participants that are of increased risk will be eligible for this benefit providing that a Letter of Medical Necessity is received from the Participant's attending physician. This includes screening mammograms that are converted to a medical diagnosis at the clinical encounter the screening is performed.
- Breast feeding support, equipment and counseling – Comprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period. Rental or purchase of one standard electric breast pump is allowed in conjunction with each birth. A standard electric breast pump is defined as double electric pump and does not include Hospital grade pumps. Breast pumps purchased from a retail store will be paid at the Preferred Provider level of benefits and Usual and Customary and Reasonable does not apply. Purchases from a retail store must be paid for up front and the receipt submitted to the Claims Administrator for reimbursement. Rental of a hospital grade pump is covered when Medically Necessary as a result of maternal-infant separation due to illness, prematurity or hospitalization and only for the duration of the separation. If rented, the allowed rental cost will not exceed the purchase price.
- Cervical cancer and dysplasia screening for women ages 21 to 65 years with cytology (Pap smear) every 3 years or, for women ages 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years
- Chlamydia and gonorrhea screening in sexually active women age 24 years or younger and in older women who are at increased risk for infection

- Contraception and contraceptive counseling – All food and drug administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity, as prescribed
- Domestic/intimate partner violence – Annual screening and counseling for interpersonal and domestic violence for women of childbearing age.
- Folic Acid daily supplements containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid for women who may become pregnant
- Gestational diabetes screening in pregnant women after 24 weeks of gestation
- Hepatitis B screening for pregnant women at their first prenatal visit
- HIV and syphilis screening
- Human papillomavirus (HPV) DNA testing in women with normal cytology results. Screening should begin at 30 years of age and should occur no more frequently than every 3 years
- Osteoporosis screening for women age 65 years and older and in younger women whose fracture risk is equal to or greater than that of a 65-year-old white woman who has no additional risk factors
- Preeclampsia prevention low-dose aspirin (81 mg/d) for pregnant women after 12 weeks of gestation who are at high risk
- Rh incompatibility screening for all pregnant women during their first visit for pregnancy-related care. Also repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24 to 28 weeks' gestation unless the biological father is known to be Rh (D)-negative.
- Tobacco use screening and behavioral interventions for cessation for all pregnant women who use tobacco
- Well-woman visits – Visit for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care. Frequency: Annual, although HHS recognizes that several visits may be needed to obtain all necessary recommended preventive services, depending on a woman's health status, health needs, and other risk factors.

Preventive Services for Children

- Alcohol and Drug Use assessments
- Autism screening for children at 18 and 24 months
- Behavioral assessments
- Cervical Dysplasia screening
- Congenital Hypothyroidism screening for all newborns
- Dental caries prevention up to age 5 – Limited to fluoride varnish to primary teeth and oral fluoride. Oral fluoride supplementation starting at age 6 months for children whose water supply is fluoride deficient.
- Depression screening
- Developmental screening for children under age 3 and surveillance throughout childhood
- Domestic/intimate partner violence – Annual screening and counseling for interpersonal and domestic violence for women of childbearing age.
- Dyslipidemia screening
- Fluoride Chemoprevention supplements
- Gonorrhea prevention medication for the eyes of all newborns
- Hearing screening for all newborns
- Height, weight and Body Mass Index measurements
- Hematocrit or Hemoglobin screening
- Hemoglobinopathies or sickle cell screening for newborns
- Hepatitis B screening for children at high risk for infection
- HIV screening for children ages 15 to 17 years and for younger children who are at increased risk

- Immunization vaccines for children from birth to age 18 – doses, recommended ages and recommended populations vary:
  - Diphtheria, Tetanus, Pertussis (whooping cough)
  - Haemophilus influenzae type b
  - Hepatitis A
  - Hepatitis B
  - Human Papillomavirus (HPV)
  - Inactivated Poliovirus
  - Influenza (flu)
  - Measles, Mumps, Rubella
  - Meningococcal (e.g., meningitis)
  - Pneumococcal (e.g., pneumonia)
  - Rotavirus
  - Varicella (chicken pox)
- Iron supplements for children ages 6 to 12 months
- Lead screening
- Medical History
- Obesity screening for children ages 6 years and older followed by comprehensive, intensive behavioral interventions to promote improvement in weight status
- Oral Health risk assessment
- Phenylketonuria (PKU) screening for this genetic disorder in newborns
- Routine hearing exams
- Sexually transmitted infections – Intensive behavioral counseling for all sexually active adolescents.
- Skin cancer behavioral counseling for children who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk
- Syphilis screening for children at increased risk
- Tobacco use interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents
- Tuberculin testing
- Vision screening for all children at least once between the ages of 3 and 5 years to detect the presence of amblyopia or its risk factors

21. **Covered Expenses –** removed items for routine physical examinations, well-baby care, and breast feeding equipment since these are now covered under Preventive Services.

22. (Item 29) **Charges Not Covered –** amended for clarification.

    29. recreational and educational therapy; learning disabilities; behavior modification therapy; any form of non-medical self-care or self-help training, including any related diagnostic testing; music therapy; health club memberships will not be considered eligible. This exclusion will not apply to diabetic self-management education programs or expenses related to the diagnosis, testing and treatment of ADD or ADHD or autism disorder, Asperger's syndrome, and any pervasive development disorder not otherwise specified.

23. (Item 51) **Charges Not Covered –** added for clarification.

    51. pool therapy, aquatic therapy and hydrotherapy, except as specifically provided in the Plan. Charges for aquatic exercise programs or separate charges for the use of a pool will not be considered eligible.

24. **Definitions –** added for clarification.

FAMILY AND MEDICAL LEAVE ACT OF 1993 – All previous provisions including coverage under this Plan, effective date of coverage and termination of coverage are intended to be in compliance with the Family and Medical Leave Act of 1993 (FMLA), as amended. To the extent the FMLA applies to the Employer, group health benefits may be maintained during certain leaves of absence at the level and under the conditions that would have been present as if employment had not been interrupted. Employee eligibility requirements, the obligations of the Employer and Employee concerning conditions of leave, notification and reporting requirements are specified in the FMLA. Any plan provisions which conflict with the FMLA are superseded by the FMLA to the extent such provisions conflict with the FMLA.

FINAL INTERNAL ADVERSE BENEFIT DETERMINATION shall mean an Adverse Benefit Determination that has been upheld by the Plan at the conclusion of the internal claims and appeals process, or an Adverse Benefit Determination with respect to which the internal claims and appeals process has been deemed exhausted.

PREVENTIVE CARE means certain Preventive Care services. This Plan intends to comply with the Affordable Care Act's (ACA) requirement to offer in-Network coverage for certain preventive services without cost-sharing. To comply with the ACA, and in accordance with the recommendations and guidelines, the Plan will provide in-Network coverage for:

1. Evidence-based items or services rated A or B in the United States Preventive Services Task Force recommendations;
2. Recommendations of the Advisory Committee on Immunization Practices adopted by the Director of the Centers for Disease Control and Prevention;
3. Comprehensive guidelines for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA); and
4. Comprehensive guidelines for women supported by the Health Resources and Services Administration (HRSA).

Copies of the recommendations and guidelines may be found here: http://www.uspreventiveservicestaskforce.org or at https://www.healthcare.gov/preventive-care-benefits. For more information, you may contact the Plan Administrator / Employer.

USERRA means the Uniformed Services Employment and Reemployment Rights Act under which Employees will be eligible for coverage on the date they return to work, provided the Employee returns to work with the Employer within the specified time period in the Uniformed Services Employment and Reemployment Rights Act (USERRA). Coverage for a reservist will be on the same basis it is for active Employees and dependents. Eligibility Waiting Periods will be imposed only to the extent they are applicable prior to the period of uniformed services.

25. (Item 3) **Provision for Coordination of Benefits with Medicare –** amended for clarification.

PROVISION FOR COORDINATION OF BENEFITS WITH MEDICARE

Definitions

3. "Full Medicare Coverage" means coverage for all of the benefits provided under Medicare including Medicare Part D, and any benefits provided on an optional basis. For the purpose of this Provision, a Fully Covered Person will be considered to have Full Medicare Coverage. (Medicare Part D election is only applicable to Employees and dependents with a retirement date on or after June 1, 2014.)

26. **Health Claim Provisions –** removed entire section and replaced as follows:

HEALTH CLAIM PROVISIONS

Health Claims
All claims and questions regarding health claims should be directed to Benefit Plan Administrators. The Plan Administrator shall be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims in accordance with the following provisions and with ERISA. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the Participant is entitled to them. The responsibility to process claims in accordance with the Plan Document may be delegated to Benefit Plan Administrators provided, however, that Benefit Plan Administrators is not a fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion.

Each Participant claiming benefits under the Plan shall be responsible for supplying, at such times and in such manner as the Plan Administrator in its sole discretion may require, written proof that the expenses were Incurred or that the benefit is covered under the Plan. If the Plan Administrator in its sole discretion shall determine that the Participant has not Incurred a Covered Expense or that the benefit is not covered under the Plan, or if the Participant shall fail to furnish such proof as is requested, no benefits shall be payable under the Plan.

A call from a Provider who wants to know if an individual is covered under the Plan, or if a certain procedure is covered by the Plan, prior to providing treatment is not a "claim," since an actual Claim for Benefits is not being filed with the Plan. These are simply requests for information, and **any response is not a guarantee of benefits, since payment of benefits is subject to all Plan provisions, limitations and exclusions.** Once treatment is rendered, a Clean Claim must be filed with the Plan (which will be a "Post-Service Claim"). At that time, a determination will be made as to what benefits are payable under the Plan.

A Participant has the right to request a review of an Adverse Benefit Determination. If the claim is denied at the end of the appeal process, as described below, the Plan's final decision is known as a final Adverse Benefit Determination. If the Participant receives notice of a final Adverse Benefit Determination, or if the Plan does not follow the claims procedures properly, the Participant then has the right to request an independent external review. The external review procedures are described below.

The claims procedures are intended to provide a full and fair review. This means, among other things, that claims and appeals will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making these decisions.

Benefits will be payable to a Plan Participant, or to a Provider that has accepted an Assignment of Benefits as consideration in full for services rendered.

According to Federal regulations which apply to the Plan, there are four types of claims: Pre-service (Urgent and Non-Urgent), Concurrent Care and Post-service.

- Pre-Service Claims. A "Pre-Service Claim" is a claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

  A "Pre-Service Urgent Care Claim" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Participant or the Participant's ability to regain maximum function, or, in the opinion of a Physician with knowledge of the Participant's medical condition, would subject the Participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If the Plan does not require the Participant to obtain approval of a specific medical service prior to getting treatment, then there is no Pre-Service Claim. The Participant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment and files the claim as a Post-Service Claim.

- Concurrent Claims. A "Concurrent Claim" arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either:

  - The Plan Administrator determines that the course of treatment should be reduced or terminated; or

  - The Participant requests extension of the course of treatment beyond that which the Plan Administrator has approved.

  If the Plan does not require the Participant to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Plan Administrator to request an extension of a course of treatment. The Participant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment and files the claim as a Post-Service Claim.

- Post-Service Claims. A "Post-Service Claim" is a claim for a benefit under the Plan after the services have been rendered.

When Health Claims Must Be Filed
Post-service health claims must be filed with Benefit Plan Administrators within 365 days of the date charges for the services were Incurred. Benefits are based upon the Plan's provisions at the time the charges were Incurred. **Claims filed later than that date shall be denied.**

A Pre-Service Claim (including a Concurrent Claim that also is a Pre-Service Claim) is considered to be filed when the request for approval of treatment or services is made and received by Benefit Plan Administrators in accordance with the Plan's procedures.

Upon receipt of the required information, the claim will be deemed to be filed with the Plan. Benefit Plan Administrators will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested as provided herein. This additional information must be received by Benefit Plan Administrators within 45 days from receipt by the Participant of the request for additional information. **Failure to do so may result in claims being declined or reduced.**

Timing of Claim Decisions
The Plan Administrator shall notify the Participant, in accordance with the provisions set forth below, of any Adverse Benefit Determination (and, in the case of Pre-Service Claims and Concurrent Claims, of decisions that a claim is payable in full) within the following timeframes:

- Pre-Service Urgent Care Claims:

  - If the Participant has provided all of the necessary information, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim.

  - If the Participant has not provided all of the information needed to process the claim, then the Participant will be notified as to what specific information is needed as soon as possible, but not later than 72 hours after receipt of the claim.

- The Participant will be notified of a determination of benefits as soon as possible, but not later than 72 hours, taking into account the medical exigencies, after the earliest of:

  The Plan's receipt of the specified information; or

  The end of the period afforded the Participant to provide the information.

- If there is an Adverse Benefit Determination, a request for an expedited appeal may be submitted orally or in writing by the Participant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the Participant by telephone, facsimile, or other similarly expeditious method. Alternatively, the Participant may request an expedited review under the external review process.

- Pre-Service Non-Urgent Care Claims:

  - If the Participant has provided all of the information needed to process the claim, in a Reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

  - If the Participant has not provided all of the information needed to process the claim, then the Participant will be notified as to what specific information is needed as soon as possible, but not later than 5 days after receipt of the claim. The Participant will be notified of a determination of benefits in a Reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan Administrator and the Participant (if additional information was requested during the extension period).

- Concurrent Claims:

  - Plan Notice of Reduction or Termination. If the Plan Administrator is notifying the Participant of a reduction or termination of a course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments, the Participant will be notified sufficiently in advance of the reduction or termination to allow the Participant to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated. This rule does not apply if benefits are reduced or eliminated due to plan amendment or termination. A similar process applies for claims based on a rescission of coverage for fraud or misrepresentation.

  - Request by Participant Involving Urgent Care. If the Plan Administrator receives a request from a Participant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim, as long as the Participant makes the request at least 72 hours prior to the expiration of the prescribed period of time or number of treatments. If the Participant submits the request with less than 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving urgent care and decided within the urgent care timeframe.

  - Request by Participant Involving Non-Urgent Care. If the Plan Administrator receives a request from the Participant to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving urgent care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a Pre-Service Non-Urgent Claim or a Post-Service Claim).

- Request by Participant Involving Rescission. With respect to rescissions, the following timetable applies:

Notification to Participant	30 days
Notification of Adverse Benefit Determination on appeal	30 days

- Post-Service Claims:
  - If the Participant has provided all of the information needed to process the claim, in a Reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
  - If the Participant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the Participant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the Participant will be notified of the determination by a date agreed to by the Plan Administrator and the Participant.
- Extensions – Pre-Service Urgent Care Claims. No extensions are available in connection with Pre-Service Urgent Care Claims.
- Extensions – Pre-Service Non-Urgent Care Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 15-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.
- Extensions – Post-Service Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.
- Calculating Time Periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

Notification of an Adverse Benefit Determination
The Plan Administrator shall provide a Participant with a notice, either in writing or electronically (or, in the case of Pre-Service Urgent Care Claims, by telephone, facsimile or similar method, with written or electronic notice). The notice will contain the following information:

- Information sufficient to allow the Participant to identify the claim involved (including date of service, the healthcare provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
- A reference to the specific portion(s) of the plan provisions upon which a denial is based;
- Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim;
- A description of any additional information necessary for the Participant to perfect the claim and an explanation of why such information is necessary;

- A description of the Plan's internal appeals and external review processes and the time limits applicable to the processes. This description will include information on how to initiate the appeal and a statement of the Participant's right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on final review;

- A statement that the Participant is entitled to receive, upon request and free of charge, Reasonable access to, and copies of, all documents, records and other information relevant to the Participant's Claim for Benefits;

- The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);

- Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to the Participant, free of charge, upon request;

- In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the Participant, free of charge, upon request;

- Information about the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review processes; and

- In a claim involving urgent care, a description of the Plan's expedited review process.

Appeal of Adverse Benefit Determinations

Full and Fair Review of All Claims

In cases where a Claim for Benefits is denied, in whole or in part, and the Participant believes the claim has been denied wrongly, the Participant may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a Participant with a Reasonable opportunity for a full and fair review of a claim and Adverse Benefit Determination. More specifically, the Plan provides:

- Participants at least 180 days following receipt of a notification of an initial Adverse Benefit Determination within which to appeal the determination;

- Participants the opportunity to submit written comments, documents, records, and other information relating to the Claim for Benefits;
- Participants the opportunity to review the Claim file and to present evidence and testimony as part of the internal claims and appeals process;

- For a review that does not afford deference to the previous Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;

- For a review that takes into account all comments, documents, records, and other information submitted by the Participant relating to the claim, without regard to whether such information was submitted or considered in any prior benefit determination;

- That, in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a Health Care Professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual;

- For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice;

- That a Participant will be provided, free of charge: (a) Reasonable access to, and copies of, all documents, records, and other information relevant to the Participant's claim in possession of the Plan Administrator or Benefit Plan Administrators; (b) information regarding any voluntary appeals procedures offered by the Plan; (c) information regarding the Participant's right to an external review process; (d) any internal rule, guideline, protocol or other similar criterion relied upon, considered or generated in making the adverse determination; and (e) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances; and

- That a Participant will be provided, free of charge, and sufficiently in advance of the date that the notice of Final Internal Adverse Benefit Determination is required, with new or additional evidence considered, relied upon, or generated by the Plan in connection with the Claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a Reasonable opportunity for the Participant to respond to such new evidence or rationale.

Requirements for Appeal
The Participant must file the appeal in writing (although oral appeals are permitted for Pre-Service Urgent Care Claims) within 180 days following receipt of the notice of an Adverse Benefit Determination. For Pre-Service Urgent Care Claims, if the Participant chooses to orally appeal, the Participant may telephone:

Benefit Plan Administrators of Eau Claire, Inc.
402 Graham Avenue – 4th Floor
Eau Claire, WI 54701
Phone: (715) 832-5535
Phone: (800) 236-7789
Fax: (715) 838-8507
www.bpaco.com

American Health Holding, Inc.
7400 West Campus Road
New Albany, OH 43054
Phone: (800) 641-3224 ext. 79101
Fax: (866) 881-9648
www.AHH_appeals@ahhinc.com

To file an appeal in writing, the Participant's appeal must be addressed as follows and mailed or faxed as follows:

Benefit Plan Administrators of Eau Claire, Inc.
402 Graham Avenue – 4th Floor
Eau Claire, WI 54701
Phone: (715) 832-5535
Phone: (800) 236-7789
Fax: (715) 838-8507
www.bpaco.com

American Health Holding, Inc.
7400 West Campus Road
New Albany, OH 43054
Phone: (800) 641-3224 ext. 79101
Fax: (866) 881-9648
www.AHH_appeals@ahhinc.com

It shall be the responsibility of the Participant to submit proof that the Claim for Benefits is covered and payable under the provisions of the Plan. Any appeal must include:

- The name of the Employee/Participant;
- The Employee/Participant's social security number;
- The group name or identification number;
- All facts and theories supporting the Claim for Benefits. **Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the Participant will lose the right to raise factual arguments and theories which support this claim if the Participant fails to include them in the appeal**;
- A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
- Any material or information that the Participant has which indicates that the Participant is entitled to benefits under the Plan.

If the Participant provides all of the required information, it may be that the expenses will be eligible for payment under the Plan.

Timing of Notification of Benefit Determination on Review
The Plan Administrator shall notify the Participant of the Plan's benefit determination on review within the following timeframes:

- Pre-Service Urgent Care Claims: As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the appeal.
- Pre-Service Non-Urgent Care Claims: Within a Reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal.
- Concurrent Claims: The response will be made in the appropriate time period based upon the type of claim – pre-service urgent, pre-service non-urgent or post-service.
- Post-Service Claims: Within a Reasonable period of time, but not later than 60 days after receipt of the appeal.

- Calculating Time Periods. The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on Review
The Plan Administrator shall provide a Participant with notification, with respect to Pre-Service Urgent Care Claims, by telephone, facsimile or similar method, and with respect to all other types of claims, in writing or electronically, of a Plan's Adverse Benefit Determination on review, setting forth:

- Information sufficient to allow the Participant to identify the claim involved (including date of service, the healthcare provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
- A reference to the specific portion(s) of the plan provisions upon which a denial is based;
- Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim, and a discussion of the decision;
- A description of any additional information necessary for the Participant to perfect the claim and an explanation of why such information is necessary;
- A description of available internal appeals and external review processes, including information regarding how to initiate an appeal;
- A description of the Plan's review procedures and the time limits applicable to the procedures. This description will include information on how to initiate the appeal and a statement of the Participant's right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on final review;
- A statement that the Participant is entitled to receive, upon request and free of charge, Reasonable access to, and copies of, all documents, records, and other information relevant to the Participant's Claim for Benefits;
- The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);
- Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to the Participant, free of charge, upon request;
- In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the Participant, free of charge, upon request; and
- The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

Furnishing Documents in the Event of an Adverse Determination
In the case of an Adverse Benefit Determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in the section relating to "Manner and Content of Notification of Adverse Benefit Determination on Review" as appropriate.

Decision on Review
If, for any reason, the Participant does not receive a written response to the appeal within the appropriate time period set forth above, the Participant may assume that the appeal has been denied. The decision by the Plan Administrator or other appropriate named fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. **All claim review procedures provided for in the Plan must be exhausted before any legal action is brought.**

External Review Process

A. Scope

1. The Federal external review process does not apply to a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a participant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan.

2. The Federal external review process applies only to:
   (a) An Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is Experimental or Investigational), as determined by the external reviewer; and
   (b) A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

B. Standard external review

Standard external review is external review that is not considered expedited (as described in paragraph B of this section).

1. Request for external review. The Plan will allow a Claimant to file a request for an external review with the Plan if the request is filed within four (4) months after the date of receipt of a notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

2. Preliminary review. Within five (5) business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:
   (a) The Claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;

(b) The Adverse Benefit Determination or the final Adverse Benefit Determination does not relate to the Claimant's failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination);
(c) The Claimant has exhausted the Plan's internal appeal process unless the Claimant is not required to exhaust the internal appeals process under the interim final regulations; and
(d) The Claimant has provided all the information and forms required to process an external review.

Within one (1) business day after completion of the preliminary review, the Plan will issue a notification in writing to the Claimant. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and the Plan will allow a Claimant to perfect the request for external review within the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

3. Referral to Independent Review Organization. The Plan will assign an independent review organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review. Moreover, the Plan will take action against bias and to ensure independence. Accordingly, the Plan will contract with (or direct the Claims Processor to contract with, on its behalf) at least three (3) IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent unbiased method for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

4. Reversal of Plan's decision. Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Plan will provide coverage or payment for the claim without delay, regardless of whether the plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

C. Expedited external review

1. Request for expedited external review. The Plan will allow a Claimant to make a request for an expedited external review with the Plan at the time the Claimant receives:
   (a) An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the Claimant for which the timeframe for completion of a standard internal appeal under the interim final regulations would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function and the Claimant has filed a request for an expedited internal appeal; or
   (b) A Final Internal Adverse Benefit Determination, if the Claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received Emergency Services, but has not been discharged from a facility.

2. Preliminary review. Immediately upon receipt of the request for expedited external review, the Plan will determine whether the request meets the reviewability requirements set forth in paragraph A.2 above for standard external review. The Plan will immediately send a notice that meets the requirements set forth in paragraph A.2 above for standard external review to the Claimant of its eligibility determination.

3. Referral to independent review organization. Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements set forth in paragraph A.3 above for standard review. The Plan will provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

   The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

4. Notice of final external review decision. The Plan's (or Claim Processor's) contract with the assigned IRO will require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth in paragraph A.3 above, as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO will provide written confirmation of the decision to the Claimant and the Plan.

Appointment of Authorized Representative
A Participant is permitted to appoint an Authorized Representative to act on his or her behalf with respect to a benefit claim or appeal of a denial. An Assignment of Benefits by a Participant to a Provider will not constitute appointment of that Provider as an Authorized Representative. To appoint such a representative, the Participant must complete a form which can be obtained from the Plan Administrator or the Benefit Plan Administrators. However, in connection with a claim involving Urgent Care, the Plan will permit a Health Care Professional with knowledge of the Participant's medical condition to act as the Participant's Authorized Representative without completion of this form. In the event a Participant designates an Authorized Representative, all future communications from the Plan will be with the representative, rather than the Participant unless the Participant directs the Plan Administrator, in writing, to the contrary.

Physical Examinations
The Plan reserves the right to have a Physician of its own choosing examine any Participant whose condition, Illness or Injury is the basis of a claim. All such examinations shall be at the expense of the Plan. This right may be exercised when and as often as the Plan may reasonably require during the pendency of a claim. The Participant must comply with this requirement as a necessary condition to coverage.

Autopsy
The Plan reserves the right to have an autopsy performed upon any deceased Participant whose condition, Illness or Injury is the basis of a claim. This right may be exercised only where not prohibited by law.

Payment of Benefits
All benefits under this Plan are payable, in U.S. Dollars, to the covered Employee whose Illness or Injury, or whose covered Dependent's Illness or Injury, is the basis of a claim. In the event of the death or incapacity of a covered Employee and in the absence of written evidence to this Plan of the qualification of a guardian for his or her estate, this Plan may, in its sole discretion, make any and all such payments to the individual or institution which, in the opinion of this Plan, is or was providing the care and support of such Employee.

Assignments
Benefits for medical expenses covered under this Plan may be assigned by a Participant to the Provider as consideration in full for services rendered; however, if those benefits are paid directly to the Employee, the Plan shall be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the covered Employee and the assignee, has been received before the proof of loss is submitted.

No Participant shall at any time, either during the time in which he or she is a Participant in the Plan, or following his or her termination as a Participant, in any manner, have any right to assign his or her right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which he or she may have against the Plan or its fiduciaries.

A provider which accepts an Assignment of Benefits, in accordance with this Plan as consideration in full for services rendered, if bound by the rules and provisions set forth within the terms of this document.

Non-U.S. Providers
Medical expense for care, supplies, or services which are rendered by a Provider whose principal place of business or address for payment is located outside the United States (a "Non U.S. Provider") are payable under the Plan, subject to all Plan exclusions, limitations, maximums and other provisions, under the following conditions:
1. Benefits may not be assigned to a Non U.S. Provider;
2. The Participant is responsible for making all payments to Non U.S. Providers, and submitting receipts to the Plan for reimbursement;
3. Benefit payments will be determined by the Plan based upon the exchange rate in effect on the Incurred Date;
4. The Non U.S. Provider shall be subject to, and in compliance with, all U.S. and other applicable licensing requirements; and
5. Claims for benefits must be submitted to the Plan in English.

Recovery of Payments
Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan's terms, conditions, limitations or exclusions, or should otherwise not have been paid by the Plan. As such this Plan may pay benefits that are later found to be greater than the Maximum Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of this Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the Plan Participant or dependent on whose behalf such payment was made.

A Plan Participant, Dependent, Provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a Plan Participant or other entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Plan Participant and to deny or reduce future benefits payable (including payment of future benefits for other Injuries or Illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other Injuries or Illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their State's health care practice acts, ICD-9 or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against the Plan Participant, Provider or other person or entity to enforce the provisions of this section, then that Plan Participant, Provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, Plan Participants and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (Plan Participants) shall assign or be deemed to have assigned to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the Plan Participant(s) are entitled, for or in relation to facility-acquired condition(s), Provider error(s), or damages arising from another party's act or omission for which the Plan has not already been refunded.

The Plan reserves the right to deduct from any benefits properly payable under this Plan the amount of any payment which has been made:

1. In error;
2. Pursuant to a misstatement contained in a proof of loss or a fraudulent act;
3. Pursuant to a misstatement made to obtain coverage under this Plan within two years after the date such coverage commences;
4. With respect to an ineligible person;
5. In anticipation of obtaining a recovery if a Plan Participant fails to comply with the Plan's Third Party Recovery, Subrogation and Reimbursement provisions; or
6. Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupation Injury or disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

The deductible may be made against any Claim for Benefits under this Plan by a Plan Participant or by any of his Covered Dependents if such payment is made with respect to the Plan Participant or any person covered or asserting coverage as a Dependent of the Plan Participant.

If the Plan seeks to recoup funds from a Provider, due to a claim being made in error, a claim being fraudulent on the part of the Provider, and/or the claim that is the result of the Provider's misstatement, said Provider shall, as part of its assignment to benefits from the Plan, abstain from billing the Plan Participant for any outstanding amount(s).

Medicaid Coverage
A Participant's eligibility for any State Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of such Participant. Any such benefit payments will be subject to the State's right to reimbursement for benefits it has paid on behalf of the Participant, as required by the State Medicaid program, and the Plan will honor any Subrogation rights the State may have with respect to benefits which are payable under the Plan.

Claims Audit
In addition to the Plan's Medical Record Review process, the Plan Administrator may use its discretionary authority to utilize an independent bill review and/or claim audit program or service for a compete claim. While every claim may not be subject to a bill review or audit, the Plan Administrator has the sole discretionary authority for selection of claims subject to review or audit.

The analysis will be employed to identify charges billed in error and/or charges that are not Usual and Customary and/or Medically Necessary and Reasonable, if any, and may include a patient medical billing records review and/or audit of the patient's medical charts and records.

Upon completion of an analysis, a report will be submitted to the Plan Administrator or its agent to identify the charges deemed in excess of the Usual and Customary and Reasonable amounts or other applicable provisions, as outlined in this Plan Document.

Despite the existence of any agreement to the converse, the Plan Administrator has the discretionary authority to reduce any charge to a Usual and Customary and Reasonable charge in accord with the terms of this Plan Document.

27. **General Provisions –** removed "Physical Examinations," "Autopsy," "Payment of Benefits," "Assignments," "Non-U.S. Providers," "Medicaid Coverage," "Recovery of Payments," and "Claims Audit" since they are stated elsewhere in the document.